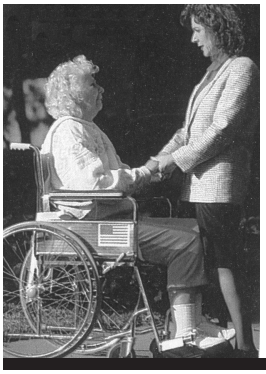

Vol 9 No 1
Winter 2010

FATE

Newsletter of Foundation Aiding The Elderly

President's Message

PATIENT RIGHTS BEING VIOLATED

by Carole Herman

Over this past year, an alarming number of complaints pertaining to patient rights violations have been reported to **FATE** and not just those occurring in nursing homes, but in acute hospitals. These complaints have been for early discharges, violations of patient rights, strong-arming of family members by nursing staff, not allowing the holders of the durable power of attorney to make decisions for their loved ones who are not capable of making decisions, over-medication and the administration of black-box drugs (including antipsychotics) without informed consent.

One case in particular that I found to be most egregious occurred in an acute hospital in Northern California. An elderly woman patient suffering from dementia was living with her husband and being cared for on a daily basis by two daughters who lived in the same town. During May of 2010, she was taken by ambulance to the hospital suffering from pneumonia and sepsis. After several days of treatment, she was doing very well…cheerful, singing, joking, eating and breathing on room air without oxygen. Then something terrible went wrong. The hospital placed her on an IV, which resulted in thrombus. The doctors then prescribed blood thinners and soon after that she had lower intestinal bleeding requiring an emergency colectomy and more than 25 units of blood to save her life. This was the beginning of extensive treatments performed on her over subsequent weeks totaling over $2 million dollars in medical costs billed to MediCare. The family questioned the doctors and hospital staff about these procedures as no one in the hospital had spoken to the family about them, nor were the two daughters who held the Durable Power of Attorney allowed to make any decisions on what care was given or not given to their mother.

CAROLE HERMAN

The family was not happy about the condition of the mother and continued to

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Warm Wishes for a Very Happy and Joyous Holiday Season with a Safe and Healthy New Year!

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Fate's Mission Is:

"Assuring our elders are treated with care, dignity and the utmost respect during their final years when they can no longer take care of themselves."

Services Fate Provides

- Direct & On Site Advocacy
- Patient & Family Rights Advice
- Elderly Service Referrals
- Long Term Care Facility Evaluation

Guardianships...Recent GAO Report

In September of 2010, The U.S. Government Accountability Office published its report on Guardianships…cases of financial exploitation, neglect and abuse of seniors and presented the findings to The Honorable Herb Kohl, Chairman of the Special Committee on Aging for the United States Senate.

FATE worked with GAO investigators who reviewed the over 200 conservatorship cases that **FATE** has documented over the past 20 years. Subsequent to the Los Angeles times expose' on guardianship abuse, the GAO was asked to verify whether allegations of abuse by guardians are widespread; examine the facts in selected closed cases and proactively test state guardian certification processes. Along with FATE, the GAO interviewed advocates for seniors, interviewed court officials, attorneys and victims and reviewed records from federal agencies. The GAO identified hundreds of allegations of physical abuse, neglect and financial exploitation by guardians in 45 states and the District of Columbia between 1990 and 2010. In 20 selected closed cases, the GAO found that guardians stole or otherwise improperly obtained over $5 million in assets from 158 incapacitated victims, many of whom were seniors.

In some cases, guardians also physically neglected and abused their victims. In 6 of 20 cases, the courts failed to adequately screen potential guardians, appointing individuals with criminal convictions or significant financial problems to manage high-dollar estates. The GAO also found that state courts fail to adequately oversee guardians after their appointment and fail to communicate with federal agencies about the abusive guardians. For many years, **FATE** has written about this on-going problem with guardianships dating back to the early 1990's with the Isabel Miller case. Hopefully, Senator Kohl and the Special Committee on Aging will hold hearings on this matter and propose federal legislation and proper federal enforcement to protect vulnerable citizens under guardianships. For a free copy go to www.gao.gov and look up the report number: GAO-10-1046.

FATE EXPANDS OPERATIONS

In light of the ever-increasing number of elderly individuals and their families in need of assistance and support dealing with improper care, inappropriate treatment and, in many cases, loss of life and property, **FATE** has expanded its operations to better serve the growing need for advocacy. The new physical address of the organization is American River Professional Centre, 3430 American River Drive, Suite 105, Sacramento, CA 95864. The mailing address is still P.O. Box 254849, Sacramento, CA 95865. **FATE** plans to add more staff and has already recruited a number of volunteers to assist in the day-to-day operations.

DONATIONS

Many of you are aware that **FATE** is a 501 ©(3), tax deductible, non-profit corporation. **FATE** does not, and will not, accept any government funds and survives and operates solely on the generosity of public donors. In order for us to continue to assist our most vulnerable citizens and their families, please consider making a tax-deductible donation by using the enclosed envelope or visiting our web site **www.4fate.org** and donating via PayPal. Thank you for your consideration.

President's Message

Continued from page 1

ask questions with little to no response from the hospital staff, including the doctors. Then another daughter, who is an R.N. and lives in another state, arrived at the hospital and began asking more medical questions and she knew what she was talking about. The hospital staff and doctors did not like being questioned and hired the hospital attorneys to file an ex-parte motion in court to appoint the hospital as the patient's legal guardian stating that the family was interfering with the mother's care, disrupting her care and disrupting the staff. No family member was given notice of this hearing held in superior court and, for some unknown reason, the judge waived the notice to the family. Shockingly, the judge granted the conservatorship based on the allegations of the hospital without any input from the family members to defend themselves against the hospital's allegations. The judge stated that entities such as hospitals, can not be guardians so guardianship was given to the public guardian's office and they immediately took control of the mother. When the family went the hospital the next day to visit their mother, they were informed that visiting hours were now being limited by the public guardian and that all medical decisions pertaining to her care would be made by the public guardian. And, the family would not be provided with any information on the condition and treatment of their mother.

For the next couple of weeks, the family attempted to convince the public guardian to move their mother to another hospital for evaluation and treatment. However, the public guardian at first refused. Then a mediation was arranged with an outside retired judge to try and resolve the issue. All parties agreed to have the mother moved to another hospital until the family received a draft of the agreement, which stated that they could not sue the hospital, nor could they file any type of complaints against the hospital or its staff with any federal or state agencies The family refused to sign the agreement. After another couple of weeks, the public guardian finally agreed to have the patient transferred to another hospital for evaluation and treatment. Even at this new hospital, the public guardian insisted that the patient's visits with family be limited and that the family was not to be told of any condition or treatment being given to their mother. The family was vigilant and stayed at the hospital only seeing their mother when allowed to by the public guardian who was in a city over 100 miles away from this hospital. The patient died a couple of weeks later.

Another very disturbing case almost parallels this one. Again, two daughters had the durable power of attorney for their father. Up until a couple of months before he got ill and ended up in an acute hospital, he had been working. He was laid off his job due to the economy. He got ill and went to an acute hospital for treatment and then was placed in a nursing home for rehabilitation. A couple of months later, he went home. However, he again became ill and was placed in the acute hospital again. At the acute hospital, he developed an infection from an unclean catheter and then without the knowledge of the family, the hospital had him sent to a nursing home for rehabilitation. When the family discovered where he was sent they had him transferred out of the nursing home back to the acute hospital where he was placed in the ICU and treated for dehydration, bedsores and another urinary tract infection from the catheter. Subsequently, the hospital elected to not treat his ailments and would not allow his daughters to make any medication decisions for him. The hospital staff told the daughters that he had signed an advance directive at the nursing home stating he did not want any life savings measures. So the hospital took this to mean that they did not have to treat him anymore. **FATE** held a conference meeting with the doctors and nursing staff clearly showing that this patient's rights were being violated and that the hospital should allow the daughters to make his medical decisions for him as he had so stated in his durable power of attorney prior to his becoming incapacitated. Unfortunately, his condition had deteriorated to the point that he died several days after the meeting.

I'm sure that anyone reading these two stories cannot believe that this can occur in America, especially since both patients had a legal durable power of attorney executed prior to becoming incapacitated naming the individuals who were to make his medical decisions for him. Well, it is occurring… and it's occurring all over the country. We should all be concerned as to why the person who has the durable power of attorney for a loved one is being denied their rights to make health care decisions when legally appointed to do so.

"It's a matter of taking the side of the weak against the strong, something the best of people have always done."

— Harriet Beecher Stowe

Litigation…Accountability for Elderly Abuse

The American Association for Justice (AAJ) released a new report in October of 2010 which illustrates how the civil justice system is the most effective force in uncovering abuses by corporate nursing homes and insurance companies that target elderly Americans. There are many laws and regulations aimed at protecting seniors; however, organizations, such as **FATE**, and media organizations consistently report that serious problems exist in our nation's nursing homes.

Large corporate chains currently run nursing homes in this country where approximately 1.5 million Americans reside. Many of these most vulnerable citizens have suffered abuse by staff members and even have died from dehydration or infection caused by inadequate care. The AAJ report explains how litigation has revealed this neglect and abuse and allowed patients and their families to hold offending corporations accountable.

AAJ President, Gibson Vance, stated that corporate nursing homes and insurance companies have continually chosen to put profits ahead of the well-being of our elderly citizens and that where regulatory and legislative bodies have been unable to cope with this distressing rise of neglect and abuse of our elderly, the civil justice system has stepped into the breach.

This year, the AAJ has fought against hidden forced arbitration clauses in nursing home contracts preventing seniors from seeking justice in court. AAJ helped move proposed nursing home legislation, and other forced arbitration bills, through hearings rounding up 115 co-sponsors in the House and 13 in the Senate. The full report can be found at: **www.justice.org/seniors**.

California's State Auditor's Report on the Department of Public Health

In June of 2010, the California State Auditor presented its audit report to the Governor, the President pro Tempore of the Senate and the Speaker of the Assembly as requested by the Joint Legislative Audit Committee regarding the California Department of Public Health's management of the State and Federal Health Facilities Citation Penalties Accounts and the effectiveness of its collection of the civil money penalties imposed on long-term health care facilities. The report concluded that the Public Health Department has overstated the fund balances for the federal account since at least fiscal year 2005-06. Specifically, during the nearly seven-year period that was reviewed, the Public Health Department imposed $8.4 million in monetary penalties but collected only $5.6 million. The audit also found that a significant amount of the monetary penalties imposed are stalled in the appeals process. From fiscal year 2003-04 through March 14,2010, facilities appealed citations totaling $15.7 million in penalties. Of this amount, citations comprising nearly $9 million were still under appeal and some of these citations were contested roughly 8 years ago.

The large number of citations stalled in the appeals process is likely due to incentives the appeals process offers facilities, including the delay of payment until the appeal is resolved and the potential that the monetary penalty will be significantly reduced. In fact, the audit showed that 71 percent of the citations issued, appealed and resolved in the time period reviewed received reductions to the original amount imposed. In particular, of the $5.3 million imposed by citations that were appealed and ultimately reduced, facility were required to pay only $2.1 million of the amount assessed. The facilities may pay 65% of the assessed penalty when ordinary citizens get a speeding ticket, no one can pay 65% of the assessed fine.

The California Department of Public Health, Licensing and Certification Division, as with all states, is responsible for licensing and monitoring more than 2,500 facilities in California. The department's staff of evaluators inspects facilities to ensure that they meet federal and statement requirements and that complaints levied against the facilities are investigated in a timely manner in order to protect our most vulnerable citizens from neglect and abuse. FATE has filed hundreds of complaints on behalf of its clients and has clearly documented that the Licensing & Certification Program is continually negligent in completing investigations in a timely manner. In fact, **FATE** still has numerous complaints outstanding that were filed over two years, and, one in particular as we go to press, it approaching 30 months old. This type of delay in holding the industry accountable for its violations of state and federal nursing home regulations that are causing our most vulnerable citizens to suffer is unacceptable behavior. Not only are our tax dollars being used to pay for these inspections, we are also paying for nursing home abuse since the majority of monies being paid to the industry are from MediCare, Medicaid and in California Medical dollars. Write to your legislator and voice your objections to the industry being protected rather than the patients. For a free copy of this report, call the California State Auditor in Sacramento at (916) 445-0255 or the report may be read on line at www.bsa.ca.gov. The report number is June 2010 Report 2010-108.

Jury Awards $28 Million in Punitive Damages In Elder Abuse Case

A Sacramento jury last May found Colonial Healthcare, a Horizon West nursing home, located in Auburn, California, guilty of elder abuse in the death of a patient and awarded a monumental punitive damage award of $28 Million for the facility's abuse and negligent care of the patient who died in 2005. The patient, Frances Tanner, who suffered from dementia entered the Colonial Healthcare facility walking, talking and eating. She had been a public servant for over thirty years and worked for the FBI, the IRS, the Department of the Army and Navy and was an assistant to General Haig as a civilian working in Vietnam for the Government during the Vietnam War. Ms. Tanner entered the facility in March of 2005 and died seven months later due to sepsis from an infected pressure sore. Ms. Tanner experienced numerous unwitnessed falls and after the last fall she was placed in bed. From that day on, she could no longer walk and she suffered severe pain. The facility failed to call the doctor and finally after more than a week of an untreated fractured hip and the development of a pressure sore, she was finally transferred to an acute hospital for surgery. Shortly thereafter, she died from sepsis due to the pressure sore.

Her daughter filed a complaint with the California Department of Public Health; however, since she was unaware of the process, she did not know what happened with that complaint. **FATE** discovered that the facility had been issued a Class B citation with a $1,000 penalty assessment for failure to provide continuing assessments of the condition of her skin, poor intake and weight loss occurring as the result of the fall and failure to develop a care plan to prevent the pressure sore. The facility contested the citation and requested a Citation Review Conference to contest the findings. As of the date of this publication, this conference has not been held and the penalty assessment has never been paid. Clearly this fits into the practice of the State as outlined in the California Auditor's Report on page 4 of this newsletter.

In the Judge's published ruling on the judgment he stated that the jury was clearly not impressed with the defense trying to convince the jury that proper care was provided and it was obvious to anyone who watched the testimony and considered the actual evidence at trial that not only didn't the facility staff regularly document rotating the patient after the hip was broken but that they didn't do the vast majority of the rotations they claimed in front of the jury to have done. The jury was obviously not impressed with two defense expert witnesses who were caught in making perjurious statements in factual representations relating to the case. Another defense "expert" witness also admitted at her deposition that she didn't know what the "standard of care" was. The judge also stated that there was overwhelming evidence of the corporate defendants running their business based, time and again, predominantly on a concern for the bottom line on the financial reports instead of any focus on compassionate patient care. The judge also determined that while the award is obviously very large, the jury had a rational basis for concluding factually that $28 million in punitive damages would be an amount that had a chance of getting defendants' attention and changing defendants' conduct in a positive fashion so that future deaths from neglect are avoided and thus he upheld the jury award.

Ohio Judge Decreases Number of Mentally Ill In Nursing Homes….

A Chicago federal judge has approved a landmark agreement that will enable thousands of people with mental illness currently living in nursing homes to move into community settings that experts say are more appropriate and less expensive than nursing homes. U. S. District Judge William Hart issued a 24-page order, signed in September 2010 that will pave the way for sweeping nursing home safety reforms that was signed into law by Gov. Pat Quinn earlier this year. This will set into motion a schedule for state officials to offer about 4,300 mentally ill people in Illinois the opportunity to move out of nursing facilities known as institutions for mental diseases. This ruling gives final court approval to a consent decree hammered out between state authorities and a class of mentally ill nursing home residents who sued five years ago on the grounds that they were not being housed in the least restrictive setting appropriate to their disabilities as required by federal law. Judge Hart agreed with state officials that the community care will be less costly for the state than nursing home costs. Judge Hart also noted that the U. S. Justice Department filed court papers urging him to approve the decree. Under the decree, state officials made a legal commitment to provide the housing and support services and the court will appoint an expert to monitor compliance.

Sepsis in the Elderly

The Journal of the American Medical Association published in October suggests that sepsis may leave some elderly individuals with long-term physical or cognitive problems. Researchers found that patients who were hospitalized with sepsis had a threefold higher risk for developing cognitive problems, such as forgetfulness, compared with the people who were hospitalized for other reasons. As well, the sepsis patients were more likely to have at least one new physical limitation, such as walking, dressing or bathing, after the hospitalization. The research also indicates that an episode of severe sepsis may represent a sentinel event in the lives of patients resulting in new and often persistent disability, in some cases even resembling dementia. It is not uncommon for elderly people to experience some long-term effects from a hospitalization; however, it is likely that the effect of the infection can degrade muscle fibers to the extent that the patient's physical strength declines. Delirium is common in severe sepsis and delirium has been linked with an increase in cognitive decline in people with Alzheimer's disease. Researchers wrote that if this data is accurate, sepsis in people age 65 and older could cause about 20,000 new cases of dementia each year. In nursing homes, patients that develop bedsores have a very high risk of sepsis, especially if the sore becomes a State IV pressure wound that has a high mortality rate. Constant turning is mandated in order to prevent sores from developing for those patients who cannot turn themselves. The development of sepsis is wide-spread when bedsores are not cared for.

Nursing Home Complaints

One of FATE's services is filing complaints with the state regulatory agencies on behalf of nursing home, assisted living, residential care and acute care hospital patients and residents. Over the past several years, FATE has averaged three to five complaints a month. Although a prompt response is required from these agencies, resource limitations can extend the process for years. Some of these complaints that FATE has filed do result in the appropriate state department citing these facilities for violations of Federal and State regulations. The following are the results of some of those complaints:

ARBOR HILLS NURSING CENTER, LA MESA, CA...DEFICIENCIES…facility accepted and acted on an "as needed" order for a chemical restraint; facility policy and procedures for "informed consent" do not reflect the actual processes described and documented by the staff for obtaining "informed consent"; facility used a chemical restraint by means of a psychoactive medication used to treat a behavior where the stated behavior posed no harm to either the patient or others in the facility and was not considered an emergency; facility failed to have completed, current clinical records for the patient.

ALVARADO HOSPITAL, SAN DIEGO, CA…DEFICIENCIES…failure to ensure a physician order relative to the administration of the antipsychotic medication Risperdal was followed in accordance with the physician's order. Drug was administered after order was cancelled by the physician.

2456 BEAUMONT STREET, SACRAMENTO, CA… UNLICENSED FACILITY…Owner operating an unlicensed facility by housing adult clients in need of care and supervision. Two residents had to be relocated to appropriate care facilities and owner had to either apply for a license to operate or no longer take in residents.

CARING FAMILIES RESIDENTIAL CARE FACILITY, ELK GROVE, CA…DEFICIENCIES…facility failed to properly care for residents during the night by double diapering residents, which caused painful skin irritations; failure to protect resident's rights by loosing the resident's hearing aids, disconnecting the resident's antenna from her television on two occasions; and failure to prevent exposure to cold drafts by leaving an entrance door open for the convenience of the staff.

DIAMOND CARE RESIDENTIAL CARE FACILITY, OAKLAND, CA…CITATIONS…facility failed to seek medical attention for resident who suffered a fall and sustained a fractured neck and a broken pelvis and who also had an untreated urinary tract infection; failure to have a signal system loud enough to summon staff in case of an accident.

EL DORADO CARE CENTER (HORIZON WEST, INC.), PLACERVILLE, CA…CLASS B CITATION…$1,000.00 ASSESSED PENALTY…failure to report an allegation of suspected abuse to the Department of Public Health within the required time period; failure to investigate the allegation of abuse until a month later; failure to implement facility policies and procedures related to elder abuse.

EL DORADO CARE CENTER (HORIZON WEST, INC.), PLACERVILLE, CA…CLASS A CITATION…$18,000.00 ASSESSED PENALTY…failure to ensure all medications were given as ordered; failure to consult with the physician when a need to alter treatment was required; failure to ensure resident requiring acute care assessment and intervention was promptly transferred to an acute hospital; failure to notify family of a change of condition; failure to ensure the patient was provided prompt care.

EL DORADO CARE CENTER (HORIZON WEST, INC.), PLACERVILLE, CA…DEFICIENCY…facility failed to employ a Director of Nurses eight hours a day on the day shift five days a week from June 11, 2009 to August 2, 2009 a period of almost two months.

EMERITUS ASSISTED LIVING, CITRUS HEIGHTS, CA…CITATIONS…$300 ASSESSED PENALTY… failure to protect resident from injuries from falls and burns; failure to administer correct medications for over six months; failure to provide sufficient staff to meet the resident's needs; failure to properly document medications; failure to document/report resident injuries; and failure to continually observe resident's major health changes.

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Nursing Home Complaints

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ESKATON GOLD RIVER LODGE ASSISTED LIVING, GOLD RIVER, CA…DEFICIENCIES…failure to respond to residents' call bells in a timely manner with one resident waiting 117 minutes for the call bell to be answered by a staff member.

ESKATON CARE /GREENHAVEN…SACRAMENTO, CA...DEFICIENCIES…failure to follow policy and procedure when a certified nursing aide turned the oxygen flow meter on and placed a nasal cannula on the patient which was out of the scope of practice for a certified nurses aide; failure to answer call lights in a timely manner and to not place the call light within reach of the patient.

ESKATON CARE CENTER MANZANITA…CARMICHAEL, CA…CLASS AA CITATION..$100,000.00 ASSESSED PENALTY…facility failed to ensure that assistance devices used in patient care were checked and maintained in accordance with manufacturer's recommendations and in a manner to prevent injury to the patient, which resulted in the patient's fall, head injury and death. Facility failed to ensure the environment is as free from accident hazards as possible and failed to provide adequate supervision and assistive devices to prevent accidents. These violations presented imminent danger that death or serious harm to the patient would result and were a direct proximate cause of death of the patient.

FLORIN HEALTHCARE CENTER, SACRAMENTO, CA...DEFICIENCIES…failure to provide copies of medical records upon receipt of written request and advance notice according to facility policy; failure to obtain family contact information during admission; failure to notify family of patient's change of condition; failure to notify family of decision to transfer patient to an acute hospital; failure to provide family contact information to the acute care hospital; failure to provide assistance to patient when the request for the use of a telephone was denied; failure to follow facility policy to safeguard personal effects of patient when items were missing upon discharge; failure to follow facility policy to maintain a belongings inventory list for patient upon transfer/discharge.

FLORIN HEALTHCARE CENTER, SACRAMENTO, CA ..DEFICIENCIES…failure to obtain informed consent for the administration of antipsychotic medications before it was administered.

FLORIN HEALTHCARE CENTER, SACRAMENTO, CA…CLASS B CITATION, $1,000 PENALTY. Failure to ensure the patient receiving antipsychotic medications did not receive an excessive dose or duplicate therapy; failure to ensure the resident receiving antipsychotic medications had adequate indications for the use and failure to ensure the patient using antipsychotic medications receives behavioral interventions in an effort to discontinue these drugs. The violation had a direct or immediate relationship to the health, safety and security of patients in this facility.

FLORIN HEALTHCARE CENTER, SACRAMENTO, CA.…CLASS B CITATION, $1,000 PENALTY. Failure to schedule additional staff as needed to ensure quality patient care based on the needs of individual patients and failure to provide a minimum of 3.2 nursing hours per patient day according to regulations. The violation had a direct or immediate relationship to the health, safety and security of patients in this facility.

FLORIN HEALTHCARE CENTER, SACRAMENTO, CA…CLASS B CITATION, $1,000 PENALTY. Failure to provide adequate supervision to prevent accidents. The violation had a direct or immediate relationship to the health, safety and security of patients in this facility.

FLORIN HEALTHCARE CENTER, SACRAMENTO, CA…DEFICIENCY…failure to notify family of a significant change in the patient's condition and failure to notify the family of the decision to transfer the patient to the acute care hospital.

FRIENDS HOUSE, SANTA ROSA, CA…DEFICIENCIES…failure to perform on-going assessment of intake and output for a resident at high risk for dehydration resulting in patient being admitted to the acute hospital with dehydration; failure to verify that resident's clinical records contained documentation of informed consent prior to initiating pspychotherapeutic medications without resident's consent and failure to ensure that a consent for psychotropic medications included the resident's name and was signed by the physician (filed by client).

MISSION CARMICHAEL HEALTHCARE…CARMICHAEL, CA…DEFICIENCY…failure to ensure intake records were kept in sufficient detail to accurately reflect patient's total intake.

MISSION CARMICHAEL HEALTHCARE…CARMICHAEL, CA…DEFICIENCIES…failure to ensure that call lights were answered promptly; failure to ensure implementation of their policy for hydration monitoring; failure to ensure implementation of their policy for all management.

ROSEWOOD TERRACE AND REHAB, CARMICHAEL, CA…CLASS A CITATION, $20,000 PENALTY ASSESSMENT. (FILED BY FAMILY)… Failure to ensure the patient environment was as free of hazards as possible; failure to ensure adequate supervision and assistive devices were provided to prevent an accident resulting in patient suffering a fracture of a cervical vertebrae after a fall from a wheelchair.

ROSEWOOD TERRACE AND REHAB, CARMICHAEL, CA…CLASS B CITATION, $800.00 PENALTY ASSESSMENT (FILED BY FAMILY)… Failure to ensure an ongoing assessment of the patient's needs; failure to ensure the patient's plan of care was reviewed, revised and updated to reflect the patient's needs.

SANTA CRUZ HEALTHCARE CENTER, SANTA CRUZ, CA…DEFICIENCIES…failure to review, evaluate and update the patient care plan as necessary by the staff in the care of the patient at least quarterly and more often if changes of condition occurs; failure to maintain current and detailed medical records for patient whose hearing aid was reported broken.

SCRIPPS MERCY HOSPITAL, SAN DIEGO, CA… DEFICIENCIES…failure to ensure the initial and on-going assessment of a patient by a registered nurse was performed and documented in the medical records of patient; failure to ensure the patient and or the person with legal responsibility to assist the patient with making decisions regarding medical care was informed of the hospital's admission agreement for services and treatment; failure to ensure the patient and/or the person with legal responsibility acknowledged the document in writing during the admission process.

SKY PARK GARDENS, SACRAMENTO, CA…DEFICIENCIES…Failure to provide heat and air conditioning in one of the rooms at this facility; failure to ensure that patient's rights by limiting visits from the family.

TWIN OAKS POST ACUTE, CHICO, CA…DEFICIENCIES…failure to complete an initial assessment within seven days of admission; failure to report a fall resulting in significant injury within 24 hours of occurrence.

VINTAGE ESTATES…SACRAMENTO, CA… DEFICIENCIES...facility failed to employ sufficient nursing staff to provide care for the patients; failure to comply with resident admission agreement policy and procedures for patient when the identified responsible party did not sign the agreement and agreement was not in the patient's chart; Failure to obtain an informed consent prior to the administration of an antipsychotic medication, namely, Zyprexa; failure to accurately and appropriately identify the responsible party in charge of making decisions for the patient and failure to provide information related to the care and treatment of the patient to the responsible party.

WALNUT WHITNEY CARE CENTER (HORIZON), CARMICHAEL, CA…DEFICIENCIES…failure to ensure patient's treatments were administered as prescribed; failure to ensure patient's related goals and facility objectives are achieved; administration of antipsychotic medications without informed consent.

WALNUT WHITNEY CARE CENTER (HORIZON) CARMICHAEL, CA…CLASS AA CITATION $80,000.00 PENALTY ASSESSMENT...failure to continually assess patient for adequate hydration and urinary tract infection; failure to provide patient with the necessary fluids for hydration. These violations presented an imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would result and were a direct proximate cause of patient's death.

Special Thanks to our Donors

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